

## Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help!

Name: \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Address: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_  Female  Male

SS#: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Do other family members come to our office?

No  Yes: \_\_\_\_\_

Person to contact in case of emergency:

Emergency contact phone #: \_\_\_\_\_

Person Responsible for Account:

Self  Spouse  Parent  Guardian

Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_  Female  Male

SS#: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred Method of Contact:

Email  Cell Phone  Home Phone

## Insurance

*We do not participate with any insurance companies. As a convenience to you, our office will fill out the necessary forms and submit them to your insurance company. We will also estimate what portion of the cost your insurance company will pay. However, we consider each patient responsible for their entire account and we require your estimated portion at the time of your visit. If the amount paid by your insurance company is greater or less than estimated, your account will be adjusted accordingly.*

### Primary Dental Insurance

Company Name: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Membership #: \_\_\_\_\_

Group #: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### Secondary Dental Insurance

Company Name: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Membership #: \_\_\_\_\_

Group #: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

(over)

**Treatment**

I hereby consent to the treatment as agreed upon, to the taking of dental x-rays for diagnostic purposes, and to the use of local anesthetics, relaxants, gas or a combination of both for completing the treatment.

**Payment**

It is expected that payment for all treatment be made in full when treatment is performed. For your convenience, we offer the following methods of payment: cash, personal check, Visa, MasterCard, or Discover. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

**Authorization, Release, and Agreement to Pay for Services Rendered**

I authorize Wooddell & Passaro to release any information, including the diagnosis and the records of treatment or examination, to third party payors, other healthcare practitioners, and/or the following individual(s):

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I authorize and hereby request my insurance company to pay directly to Wooddell & Passaro insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the total charges for services rendered by Wooddell & Passaro. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents.

**Late Charges**

If I do not pay the entire new balance within 90 days of the monthly billing date, a late charge of 1.5% will be assessed on the outstanding balance each month. I realize that failure to keep my account current may result in Wooddell & Passaro being unable to provide additional dental services unless I experience a dental emergency or prepay for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on my account.

**Appointment Times**

We see all patients on an appointed time and ask that you call to schedule appointments so that we may reserve time for you. We respect your time and will make every effort to remain on schedule and ask that you extend the same courtesy to us. If you are unable to keep a scheduled appointment, please notify us immediately. We appreciate 24 hours notice so that the time may be given to another patient. We reserve the right to charge a broken appointment fee for appointments cancelled without 24 hours notice.

I have read and understood the policies of Wooddell & Passaro and agree to follow them. I realize that if I have any questions or concerns at any time, one of the staff members or one of the doctors will be happy to assist me.

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Signature of Patient or Responsible Party

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Date